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STUDY PROJECT

TO CONSERVE THE HEALING STRENGTH

BY

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11 APRIL 1990

U.S. ARMY WAR COLLEGE, CARLISLE BARRACKS, PA 17013-5050

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The lack of adequate medical support has been termed a "war-stopper" at the highest levels of the Dept of Army. There have been many different attempts to correct this problem, including a heavy reliance on medical assets in the Reserve Components. One successful attempt was creation of a network of "Personnel Counselors" to recruit needed professionals for the U.S. Army Reserve. With a major focus on unit personnel, the network has

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been instrumental in raising Medical Corps unit officer strength levels from 23 percent in 1980 to above 85 percent of authorizations in 1989. In the annual competition for funds, and especially now with the euphoria associated with the events taking place in eastern Europe, some may feel that medical recruiting is no longer needed. Such a misguided notion would result in a diversion of the resources of the network to other problems or programs. The purpose of this study is tc examine the events which led to recognition of the "war-stopper" conditions and to present a rationale for maintaining this vital key to readiness.

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TO CONSERVE THE HEALING STRENGTH

USAWC MILITARY STUDIES PROGRAM PAPER

Individual Study Project

by

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The lack of adequate medical support has been termed a"war-stopper" at the highest levels of the Department of The Army. There have been many different attempts to correct this problem, including a heavy reliance on medical assets in the Reserve Components. One successful attempt was creation of a network of "Personnel Counselors" to recruit needed professionals for the US Army Reserve. With a major focus on unit personnel, the network has been instrumental in raising Medical Corps unit officer strength levels from 23% in 1980 to above 85% of authorizations in 1989. In the annual competition for funds, and especially now with the euphoria associated with the events taking place in eastern Europe, some may feel that medical recruiting is no longer needed. Such a misguided notion would result in a diversion of the resources of the network to other problems or programs. The purpose of this study is to examine the events which led to recognition of the "war-stopper" conditions and to present a rationale for maintaining this vital key to readiness.

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INTRODUCTION

The motto of the U.S. Army Health Services Command (HSC) is "To Conserve The Fighting Strength". It suggests the focus of this study, the retention of a system which has the demonstrated capability of ensuring a steady supply of people required by the U.S Army Medical Department (AMEDD) to meet its mission. Without question, medical shortages could be a "war-stopper". Bluntly, this means that this country will not be able to field an effective military force in any future emergency without adequate medical support in the forward combat areas.[1] This study then focuses on one of many important current Army requirements, namely the recruitment and retention of medical specialists in these changing times. This requirement will enable the U.S. Army to be prepared to adequately "Conserve The Healing Strength" in the 1990's.

No discussion of reserve component recruiting would be complete without some mention of the extreme difficulty in obtaining reliable data on reserve medical personnel. In its FY 1984 Report, the Reserve Forces Policy Board, stated: "Review and comparison of Defense Manpower Center (DMDC) and Service-provided data revealed inconsistencies, inaccuracies, and perhaps incomplete reporting practices. Since policy decisions are made using DMDC data, it is critical that data in the Reserve Component Common Personnel data base and the Service-maintained data bases be reconciled."[2]

Th[illegible] Commission expressed the same concern in its report, [illegible]ng that "An analysis of the reserve problem suffers seriously [illegible]m a lack of data."[3] This was not a new problem, but fortun[illegible]ely its seriousness has recently been raised to high levels. During this study, I have encountered the same frustration of inconsistencies, inaccuracies and incomplete reporting. Data from separate sources seldom matched. Perhaps this was due to different methods of keeping records. But whatever the reason, data from different sources almost always portrayed a different picture. At best, it is confusing. Furthermore, it compounds the difficulty of forming rational judgments about the actual state of readiness or of what needs to be done to improve it, if anything. Strong arguments for a retention of existing AMEDD apparatus become weak and ineffective without a consistent and reliable data base.

Scope and Methodology

During the 1970s and 1980s a serious problem in the U.S. military capability was recognized and solved. The author served in the Active Army and U.S. Army Reserve (USAR) during much of this period. Her personal observations, records and interviews of some who were directly involved in solving this problem will be examined. As an AMEDD Personnel Counselor, and later as Director of the Northeast Region described in this study, the author was able to visit and closely observe each medical unit in the region, as well as many other units throughout the nation. This opportunity has provided valuable perspectives for the conduct of this study. With personal experience as a starting

point, this study will consist of three basic components: The personal interviews and papers of persons directly involved in the USAR Personnel Management, a review of past studies specifically dealing with recruitment and retention of physicians in the reserve, and conclusions based on the current medical environment. To get a variety of observations, personal interviews were conducted with officers currently on active duty as well as with some who are now retired. Whenever requested to do so, each graciously shared many personal papers, files and recollections in support of this effort. Consequently, the author wishes to express profound gratitude to each of these direct sources for this study.

Review of Earlier Studies

Physician "shortages" have been perceived and studied from almost every perspective. Conclusions, recommendations or inferences from each clearly reflected the interests of those conducting the study; more charitably, it could be said that each revealed the special perspectives of the reporters and researchers.

American Medical Association Study

In 1987, the American Medical Association (AMA) published the results of its study of the attitudes held by physicians concerning military service.[4] It is important that an analysis of military recruiting include the unique perspective of this organization because of its proclaimed "representational mission on behalf of U.S. physicians". As "spokesmen" for the U.S. medical community, the AMA has the ear and attention of

Congress; consquently, its statements are always given a great amount of consideration. Thus it is essential that careful attention be given to the potential of negative impacts inherent in these AMA recommendations. The recommendations provided by the organization are as follows:

1. Medical students, particularly first-and second year-students, should be the object of additional recruiting efforts.
2. A program using physician recruiters should be initiated to contact each of the 126 medical schools with a program to interest first and second-year students in making a commitment to the reserves.
3. Loan forgiveness programs should be introduced.
4. The potential for expansion of existing surgery and anesthesiology training programs, where the additional positions would carry a service commitment, should be investigated.
5. Serious recruiting efforts should be mounted to enlist former military physicians for service with reserve units.
6. Continued emphasis on retention of active and reserve military physicians is likely to be effective; reenlistment incentive programs should be continued and enhanced.
7. The response to physician-initiated contact is more likely to raise interest in serving; more resources should be devoted to responding carefully and completely to requests for information from resident physicians as well as practicing physicians.
8. Physician recruiters should be used to follow up requests for information about service options.

9. Additional efforts should be devoted in informing physicians about the full range of options available.

10. Limited service commitments in flexible reserve units should be used to recruit physicians in surgical residency programs.

11. Outreach programs for practicing physicians should emphasize the least restrictive reserve program available, because this group will be most responsive to the limited commitment.

12. Recruiting efforts should be targeted toward employee-physicians, because they are the most receptive audience.

I believe that wholesale implementation of these recommendations would be not only expensive but also largely ineffective. We should carefully consider the potential of negative impacts inherent in several of these AMA recommendations. For example, recruiting first-year and second-year medical students for reserve units provides no immediate benefit to the units. The student cannot perform medical functions, even in peacetime. Nor can he or she be mobilized if the unit were to be called to active duty. Also, using physicians as recruiters is not realistic. Physicians are busy professionals and do not have the time required to do follow up work on potential recruits. Targeting recruiting efforts toward contract physicians does not help solve the problem either. In my experience, many such physicians were retired and in most cases over the age limit. Some were foreign and did not meet requirements for service in the military. And some were unable to meet the standard physical requirements. Even if contract

physicians were to join, the number would not be sufficient to solve the problem. Overall, the recommendations in the AMA study would be extremely expensive to implement.

The Berbary Study

Without question, the most exhaustive study of recruiting medical personnel for the Army was that of Maurice Berbary in 1969.[5] As a Medical Corps Colonel assigned to The Office of The Surgeon General, he had special insights which were based on his unique vantage point. Berbary provided some revealing details of the extensive effort needed to overcome the many legislative obstacles involved in the creation of programs to increase the number of physicians in the Army. At the time of his study, the Army was beginning to experience the effect of no draft to ensure a steady supply of physicians. As an MD, he indicated that he shared the common disdain for the "doctor draft" (PL 779 of 9 Sep 1950).[6] In fairness to him and other members of the medical community, it must be stated that this law was purely discriminatory: only male physicians were drafted, based solely on their acquired skills. Berbary also provided a great deal of information on the various options which were explored or attempted to provide a steady supply of physicians. Any future examination of this subject would be well served by a review of his work. Perhaps his single most important insight was his emphasis on the importance of personnel management and career planning to the retention of physicians. Because this author shared this view, a chapter of this study is devoted to past and present USAR personnel management.

The Vance Study

Major William Vance (later, COL, MSC) conducted another extensive study which offers even more insights into the many difficulties which surround ensuring an adequate supply of Army doctors. The Vance Study of physician recruitment was completed in 1975. By this time, the number of medical schools in the USA had doubled within the preceding 20 years. Vance recognized that there was not a physician shortage, as many had claimed. Rather he discovered difficulties in attracting available physicians into military service.[7] In contrast to the previously mentioned AMA study, he did not recommend the expenditure of vast sums of federal funds: "Many of the resources needed to alleviate this problem are already at hand and can be easily used."[8] This position was later confirmed in 1978 by the Special Officer Division at RCPAC.[9] The Special Officer Division, described in a later portion of this study, reported on attitudes expressed by over 2500 physicians concerning participation in the reserves. Again, unlike the AMA study, this effort did not call for an outlay of additional dollars but for reliance on resources already available. It called for changes in the training programs and for flexibility and alternatives to the normal utilization of physicians in the reserve. The Special Officer Division study took into account the needs and concerns of physicians. It is fortunate that the Vance and Special Officer Division study recommendations prevailed. They have guided the

approaches taken by The Surgeon General in establishing the procurement system now in use, rather than the AMA recommendations.[10]

The Bradley Study

Without question, one of the more insightful studies of the procurement and retention problems associated with the readiness of the Reserve Component (RC) units was conducted by BG Douglas Bradley, MC, California ARNG in March 1969.[11] As a physician who had served on active duty and in the ARNG for over 20 years and a practicing physician, Bradley did more than merely provide theoretical constructs. He drew on his own perspectives and a number of others who were knowledgeable in the RC. His study recognized the limits to which the federal treasury could be drained. Drawing upon his first hand observations and his practical knowledge of the RC environment, he recommended the use of modest bonuses and flexible training options. He also acknowledged what many in the RC had known for some time: the Guard and Reserve meetings were time-wasters for physicians. He called for a reduction of 50 percent in the authorized physician strength levels in units.[12] This would provide a sufficient cadre of physicians to ensure a professional orientation and training; however, it would minimize the waste of time that this officer has personnelly observed (such as training with moulages in a USAR classroom, while actual patients could have been treated if the doctor were not required to attend drill). This was not a new concept. Professional Complements were a part

of many TO&E units at varying times, but the Bradley endorsement gave needed support to what was acknowledged in the Reserve Component community for quite some time.[13] His study focuses attention on the need to understand the unique situation of the medical professional. The data clearly states that physicians are interested in career planning and personnel management. They want flexible training and alternatives to weekend drills. If the Reserve Components want to attract and retain physicians, they must offer programs that meet the doctors' needs.

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CHAPTER II

The Reserve Environment 1970-1989

To fully appreciate the seriousness of the Armys' "doctor shortage" in the latter part of 1970, we should review the Troop Program Unit (TPU) environment as it was in that decade. The studies mentioned in Chapter I were helpful primarily because they pointed out problems that needed to be looked at.

During the period of the draft, units never needed to actively seek out and attract physicians. Because of the strong possibility of being sent to a combat area, many draft-eligible physicians would seek positions in almost any medical unit, ARNG or USAR. Few units had problems in remaining at full strength; when authorized, an overstrength was easily achieved.

But the end of the draft marked a watershed for most Guard and Reserve medical units commanders.[1] Unit commanders were then charged with recruiting and strength levels. With little or no experience in recruiting, few were able to fill critical positions. The Army Medical Department had great difficulty in attracting physicians into the USAR. When the draft ended in 1973, physicians simply disappeared from the TPU USAR ranks. In testimony at the Hearing on Military Posture and HR2970 DOD Authorization for appropriation in 1981, General Berkman, Chief of the Army Reserve, stated that the Army Reserve was 73 percent short the physicians needed to full authorized slots. Doctors were leaving the reserves in large numbers, and recruitment of physicians into the USAR was just about non-existant.[2]

In some areas, the Army Reserve Command (ARCOM) created positions for ARCOM recruiters who were responsible for both recruiting and the clerical work required for enlistments or appointments. In almost every instance, the ARCOM recruiters had little success in bringing physicians into reserve units; however, there was a marked improvement in enlisted accessions.

Prior to 1973, ARNG and USAR units established waiting lists for would-be unit members. It was common to find many individuals who would travel to distant cities for reserve meetings, if they could find a unit vacancy. Waiting lists were opened and quickly closed, depending on known future vacancies. During this period, there was enormous pressure on unit commanders and staffs.[3] From every source they heard pleas on behalf of some individual about to be drafted. Anyone who held any position of authority in a unit was subject to being solicited by parents, anxious to keep their sons from being a likely soldier in Viet Nam. It was not uncommon to see lines forming as early as 0200 hours at USAR training centers, even on the basis of a rumor that a waiting list would open that day.

Reserve Retention

Retention , however, was another story. Just as there was no great pressure on units to actively recruit, there was not much incentive to be concerned about retention. Many were on the waiting lists to replace those who left. Throughout the Reserve Components, the picture was the same: turnover in personnel as soon as they reached their date of eligibility for transfer in

the Control Group.[4] Following four years service in a unit, the individual was no longer liable for the draft and was regarded as having performed his military obligation.

The 1973 Exodus

The end of the draft had a traumatic effect on unit MC strength levels.[5] Unit strength declined dramatically for two reasons: The inability to retain and the inability to bring new physicians into Troop Program Units (TPU). When draft motivated physicians completed their obligated unit service and were no longer subject to an involuntary call to active duty, they stopped attending drills. Having served in an active unit for four years, each had a remaining obligated period of two years. Rather than being discharged, as many assumed, these individuals were placed in the IRR (Individual Ready Reserve). As will be explained later, failure to understand or acknowledge this contractual obligation was a source of many problems when efforts were made to establish a personnel management system for the USAR.[6]

The Critical Year

1977 marked the critical point for Army Reserve units. It marked the fourth year after abolition of the draft. It was the time when the final wave of draft-motivated physicians could ask for transfer to the IRR.[7] The Special Officer Survey of 1978, conducted by the Special Officer Division at RCPAC, compiled the results of telephone conversations with over 2500

former u octors and confirmed that there were indeed few valid rea s for practicing physicians to join a drilling unit.[8]

Turn-around in Physician Recruitment

In 1979 the Surgeon General of the Army implemented the AMEDD Professional Procurement Network. After a year had passed, the numbers began to increase remarkably. USAR MC strength for years 1981 to 1989 show a steady increase. In his testimony, General Berkman stated that, as a result of the recent initiatives, the professional medical officer strength was projected to increase due to AMEDD recruiting efforts. The strength figures in fiscal year 1981 were projected to produce 300 physicians; this was expected to increase to 400 physicians annually thereafter for the Army Medical reserve units.[9]

The success of the AMEDD Professional Procurement Network far exceeded General Berkman's predictions in his 1981 statement. (See figure 1) This program greatly affected unit strength throughout the country. The total number of doctors assigned to units from 1979 to 1989 in-creased at a steady rate each year, except for 1984. This in part was due to the switch in emphasis from recruitment of doctors in all specialities to recruitment of doctors in critical specialities (general surgery, orthopedic surgery, internal medicine, anesthesiology, radiology, thoracic surgery, ENT, a. 'Gyn). Previously, it was difficult to recruit these crit.

specialists. It took little over a year for incentives directed at the critical specialities to be put into effect--the STRAP Program, for example.

The gap between DA authorized strength and unit strength closed significantly between 1982 to 1989. The trend (see Figure 2) reveals that more and more physicians were joining reserve units. The new government incentives and the professional USAR recruiting network had undoubtedly made a difference. Professional personnel counselors were going out into the community (visiting hospitals, teaching centers, medical centers, and doctors, speaking at medical meetings and visiting medical schools) informing the medical professional about the opportunities offered in the Medical Department Medical Corps.

Figure 1

Statical Data on AMEDD USAR Medical Corps Recruiting for Fiscal Years 1981-1989

YEAR	TOTAL MC's RECRUITED
1981	659
1982	552
1983	789
1984	628
1985	583
1986	553
1987	769
1988	765
1989	736

Source: U.S. Army Health Professional Support Agency
Office of the Surgeon General, Washington, DC., 1989

FIGURE 2

USAR Medical Corps Strength for Years 1979-1989

Year	(1) Req Strength	(2) DA Auth	(3) Shortfall	(4) % Fill	(5) IRR	(6) Stdby
79	3356	3372	2471	26.3	757	1380
80	3371	3386	2446	27.4	666	932
81	3350	3364	2288	31.7	881	675
82	3376	3387	1862	44.8	1564	3
83	3424	3436	1486	56.8	1734	7
84	3434	3430	2250	65.6	1969	2
85	3503	3513	1578	67.9	2066	2
86	3550	3557	1241	65.1	2301	1
87	3608	3610	1037	71.0	2425	1
88	3715	3717	1076	71.0	2530	4
89	3794	3792	720	81.0	2699	3

DCSPER 46 Report for Sep 1979 to Sep 1989

DAAR-MA Report on USAR AMEDD Strength

ENDNOTES

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CHAPTER III

Reserve Personnel Managenemt

The importance of effective personnel management in the recruiting and retention of professional personnel cannot be overstated. As Berbary emphasized, appropriate management of professionals is most essential to any "scheme to subsidize vocational and academic training with resulting service obligation and a likelihood of service orientation and motivation."[1] Current initiatives rely quite heavily on the vocational and academic subsidies, and proper management of these programs places heavy responsibility on the personnel manager.

The Officer Personnel System, The Army Reserve (TOPSTAR)

On 12 June 1974, five officers of the US Army Reserve were ordered to ADT for 60 days in Washington. They formed a task force which would design methods to manage the USAR. These officers became the core of what would later become known as TOPSTAR.[2] Upon completion of a model, roughly based on the MILPERCEN, the officers were then granted additional duty and ordered to the Reserve Components Personnel and Administration Center (RCPAC) in St. Louis, MO, to establish the system. RCPAC was selected because it was the respository of Army service records and could provide the necessary logistical support for the new system.

The goal of TOPSTAR was to retain pre-trained manpower in the IRR by offering annual, specialty-related training to

reservists who would otherwise elect discharge when eligible, or would be discharged for lack of participation. This was the fate of 65 percent of the junior officers, mainly graduates of the ROTC program, until late in 1977.[3] TOPSTAR was based on a concept of periodic rotation between the IRR and positions in a TPU. However, many in the USAR vigorously opposed this concept for a variety of reasons.[4] The IRR was little known and mostly misunderstood by most TPU members who wanted to remain in a paid unit position. This lack of knowledge promoted a negative image which was difficult to erase.

The TOPSTAR Personnel Management Officer (PMO)

The PMO was to be the central figure in TOPSTAR; his other job was to provide counsel and training opportunities to the reserve officer who voluntarily participated in TOPSTAR.[5] The PMO had no power to enforce either a training obligation or a unit assignment from the IRR. This was especially true in instances where field grade officers were offered for vacant unit positions. Although significant numbers of unit positions were held by unqualified officers, there was strong opposition to accepting an IRR member, however qualified.[6] The promotion of the All-Volunteer Army placed emphasis on the monetary benefit of reserve participation, and the slower economy of the early 80's made a paid unit position appealing to many who saw this as a way of gaining supplemental income. But physicians were not involved in this process, as will be seen later.

The Reserve Officer MOS (ROMOSS) Conversion

The TOPSTAR team was at RCPAC during the period when the Army decided to change Military Occupational Specialty Codes (MOS) to the new Specialty Skill Identifier (SSI). This task was assigned to the TOPSTAR team. Until this time, TOPSTAR had no involvement or familiarity with Special Branch Officers, and the assignment of this task later proved to be the source of much difficulty in Special Branch Management.[7] Team members attempted to obtain a close match between MOS and the new classificataions; however, particularly in medical specialties, there were difficulties due to the elimination of some specialties from the AMEDD inventory. In instances where an exact match was not clear, the team assigned the one that appeared to be the closest match.[8] Since Special Officer Branch was not included in the MILPERCEN model, TOPSTAR officals soon realized that,to be effective, the entire USAR had to be based on the MILPERCEN model. But the MILPERCEN model did not include management of Special Branch officers, so TOPSTAR officials then realized that, to be effective, the entire USAR had to be in the management system.[9]

Officer Personnel Management System-US Army Reserve

The concept of "centralized personnel management," first attempted in TOPSTAR, was later refined with implementation of OPMS-USAR in 1977. Although still supposedly based on the MILPERCEN model, OPMS-USAR called upon active reservists in the Special Branches to apply for active duty in St. Louis for duty

as PMO's for other reservists. In September 1977, 77 officers reported for duty to begin implementing Phase I. At first, it was anticipated that three years would be required for full implementation throughout the country. However, due to the enthusiuasm of the officers who were now back on active duty, the program was fully implemented in one year. The PMO of OPMS-USAR was featured as the central point of contact for the USAR officer. The PMO was a counselor, advisor, and trainer who had a personal concern for the career of the individual officer in the USAR, particularly one in the IRR who had no other place to turn for support.

Command Coordination

With lessons learned during TOPSTAR, OPMS-USAR created a new organizational structure for reserve management. First, it established a branch to manage Special Officers (Chaplains, Judge Advocate Generals, and AMEDD). Next, it established the Command Coordination Division from which OPMS officers were dedicated to specific major USAR Commands (MUSARCS) to serve as points of contact. This was a major change from TOPSTAR, which relied on personnel within the MUSARC to perform these duties.[10] By dedicating its own resources to the commands for coordinating assignments, OPMS not only gained a greater effectiveness in the process, it clearly demonstrated a new determination of the Army to effectively manage its reserve assets.

AMEDD Personnel Management by OPMS-USAR

Management of AMEDD, Chaplain and JAG Officers began on 1 Nov 1977 with creation of the Special Officer Division in the Officer Personnel Management Division (OPMD) at RCPAC.[11] As in the other branches, the initial task was to locate an officer, establish a personnl file and evaluate the status of the officer's career and training needs. The major focus was on the junior officers, especially in the combat, combat support and combat service support branches. However, AMEDD officers of all ages were eagerly sought for training tours. Prior to the creation of the division, there had been little in the way of a structured means of having medical personnel of the IRR perform tours in medical facilities. There were a few who "knew the RCPAC system" and obtained ADT orders to serve at some installations, but the numbers were so small as to make little impact on HSC. HSC had been at a manning level for several years, so it too looked for reserve support in every installation. The responsibility for coordinating a reserve tour was given to the Reserve Advisor at HSC. Through a call to RCPAC, the Advisor could arrange a tour for a member of the IRR. However, without a personnel data-base a pro-active search was not possible. The Advisor passively waited to be contacted.[12] But a new, pro-active ball game commenced on 1 November 1977. IRR doctors no longer had to make ADT calls, rather OPMD began calling the doctors.

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CHAPTER III

1. Maurice S. Berbary, The Physician, The Congress, and The Armed Forces, Carlisle Barracks, Pa: The US Army War College 1969. pp. 20-26
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CHAPTER IV

Reserve Medical Training in the Late 1980's

The training of Reserve Component medical personnel has been improved to a significant extent during the past ten years. This improvement is the result of two factors: the previously cited active force shortages and an increased realization of the extent to which the AMEDD had to rely on the RC to perform its peacetime and wartime missions. Army Reserve medical personnel and units are a vital part of the Total Army. The Reserve Components will provide 65 percent of the physicians, 82 percent of the nurses, and 68 percent of the enlisted medical soldiers necessary for mobilization.[1] In the Comptroller General's Report to Congress "Will There Be Enough Trained Medical Personnel in Case of War?" (HRD-81-67, June 24, 1981), he discussed the shortage of skilled medical personnel in the Regular and Reserve forces.[2] As pointed out in the previous studies, the importance of innovative and beneficial training is essential if reserve units are going to retain and recruit qualified physicians.

Without question, this improved training environment has contributed to the retention of some medical personnel who would otherwise have left the RC, because of reasons cited in previous studies.[3] In addition, improved opportunities for training which lead to new skills or educational levels have been instrumental in improving recruitment.

For many years, it has been claimed that "flexibility in

training is the key to attracting and retaining medical personnel in USAR units.[4] Flexible training allows a physician the opportunity to participate in the reserve program even through his time my be limited. Flexible training takes into account that physicians have schedules demanding large amounts of their time. Allowing doctors to work at hospitals, clinics, and military facilities and to attend medical lectures and continuing health education courses scheduled around their free time only enhances their medical skills and benefits the military. The two-week summer camp commitment has also presented a major problem for physicians. This can now be broken up: one week attending a medical convention of their choice, then one week spent with a unit on annual training.[5]

Similarly, it has been recognized that the locations of medical units and sizable medical populations did not always coincide. Despite the extreme difficulties encountered in moving units from one community to another, the Army has come to accept proposals which have been made since 1978.[6] Reservists can now be assigned to vacant unit positions in any part of the country, regardless of their own geographic location. This allows the physician the opportunity to belong to a unit when there may not be a medical unit near his/her home or a unit vacancy in a unit closer to his/her home. The physician can choose to drill with that unit if he or she so desires. They will be paid for the 16 hours of drill time, but any expense incurred to and from the

unit is the responsibility of the individual. It also allows the physician to participate with another unit closer to his/her home or to give his/her reserve time to a hospital or medical facility in his area. Doctors are given the option to work out their commitments at the times and places best suited to their professional agendas. Although this had been standard practice in some commands in earlier years, only recently has it become Army policy to permit such distant assignments.[7]

ENDNOTES
CHAPTER IV

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CHAPTER V

Initiatives to attract Physician In The Eighty's

In recognizing that the military must compete with the private sector for the available time of medical personnel, the services have introduced a number of incentives which are helping to attract significant physician interest. These incentives have been provided through several programs: the Loan Repayment Program (LRP), Medical Detachment Program (MEDDET's), Continuing Health Education Programs (CHE), National Augmentation Detachment Program (NAD), and the Stipend Program (STRAP). Flexible training and courses such as the Deployment Medical Course have been instituted specifically for the physician. All have made a positive difference in the recruitment of physicians into the USAR.

Let's briefly review how these programs work:

Loan RepaymentProgram

Specifically designed for physicians and nurses in skills determined to be critical wartime shortages, The Education Loan Repayment Program for Health Professionals offers up to $3,000 forgiveness of education loans for each year of satisfactory service, with a total program repayment up to $20,000.[1]

Medical Detachments (MEDDET's)

Many Army Reserve medical units have established affiliations with civilian and military treatment facilities in the search for rewarding training. An example of this flexible training has been the MEDDET's.

Under this program doctors and nurses with critical skills can spend their drill time in special detachments that have agreements with their units. Many of the Medical Detachments are located near medical schools or teaching hospitals where the training is conducted. These MEDDET's are located in almost every part of the country.[2]

Continuing Health Education Programs

The Continuing Health Education Program is another incentive that the Army Reserve has established to retain Army Reserve medical professionals. Professionals need to keep their licenses or credentials valid. Under this program physicans get credit for attending a military or civilian training course each year in a paid drill status.[3]

National Augmentation Detachments (NAD)

The NAD is intended to provide an administrative and training elemert for health professionals assigned to Army Reserve medical units who are available to train with their units on a regular basis. In the program, physicians will be assigned to vacancies in Army Reserve units without regard to geographic location, attached to the NAD, but counted as mobilization assets of their assigned units. Participants are allowed to fragment annual training (AT) and up to 48 inactive duty training (IDT) periods . IDT training is tailored to each physician's specialty and may be performed in a variety of settings. In addition, NAD participants will attend advanced military education and continuing health education courses in AT/ADT status.[4]

The Specialized Training Assistance Program (STRAP)

The Specialized Training Assistance Program was designed to attract doctors and nurses in surgical specialties. STRAP provides a sliding scale of stipends, varying according to the obligation incurred, to Army Reservists training in general surgery, anesthesiology, orthopedic surgery, operating room nursing, nurse anesthesis, and medical-surgical nursing. Participants may elect full stipend payments or one-half stipend payments .[5]

The program is open to those currently serving in the reserve components. Qualified applicants for appointment are offered a commission as Medical Corps or Army Nurse Corps officers.

Flexibility in weekend drill participation

Under this option, unit attendance policy allows the doctor with a heavy work or hospital commitment to be excused from 25 percent of unit drills by their immediate commander. Another 25 percent of unit drills can be excused by the next higher commander.[6]

These programs have been designed to provide financial incentives, worthwhile training opportunities, and geographic flexibility to medical professionals whose skills are essential to AMEDD's missions and warfighting capabilities. All of these programs have been designed to provide incentives for medical personnel to join reserve component units. Further, they are

designed to enable these personnel with a variety of flexible options for fulfilling their military obligations and for remaining in active status in their own units.

ENDNOTES
CHAPTER V

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CHAPTER VI

Reserve Medical Recruiting in the 1980's

Increased training opportunities for physicians and greater flexibility in meeting military requirements have provided excellent groundwork for reserve medical recruiting in the 1990's. This recruiting was systematically carried out by the AMEDD Recruiting Network.

Before the AMEDD Procurement Network began, there had been no organized Army Medical Department efforts that specifically focused on attracting doctors and other health care professionals into the reserves.[1] The Surgeon General of the Army was given the responsibility to implement a professional organization made up of officers who held degrees and had experience in the health care area.

Counselors for the AMEDD Network were selected very carefully, because it was important to have people who were professionals and who could appeal to physicans on a professional level.[2] Most counselors selected had civilian jobs associated with the medical professions.

The Army Medical Department Procurement Network originally started with only five Officers in 1979. Five Regional Directors assumed responsibily for starting up the USAR professional recruiting network. In 1980 twenty additional officers were brought on board as personnel counselors to recruit for the USAR. The second wave of twenty-two counselors were brought on

in 1981. Currently, the AMEDD Network has fifty-one personnel counselors located in the five different regions throughout the United States.

The success of physician recruitment must be credited to the outstanding ability of this highly skilled and motivated group of Personnel Counselors.[3] As a personnel counselor myself from June 1981 to August 1984, I can speak from experience about what it takes to be a successful counselor. During the four years I spent as a counselor, I was selected each year as one of the top producers in the region and the country. The key to a counselor's success is their thorough knowledge of what physicians are interested in. Counselors need to understand and clearly articulate the different programs; they must show how the programs work and how they will benefit the physician. The programs they sell must be flexible and must be able to fit into the lifestyle of the busy doctor. The counselor must be able to interact on a professional level with the physician, because the physician is the expert in his/her area. But the counselor is the expert in his/her area.

The most successful counselors were those who had experience selling or working in hospitals, doctors' offices, or in jobs that allowed them to interact with the medical professional. Counselors must make themselves available to assist the physician whenever called upon. The quality service that you render a new prospect, counselors' follow-up activities, and your belief in your programs are the keys for the successful counselor.

Counselors focus on recruiting the brightest and the best in the medical profession. They have in fact sought out qualified doctors for over three hundred USAR Medical Units in the Continental U.S. and Puerto Rico.[4]

Unit shortages of surgeons, operating room nurses, nurse anesthetists, and enlisted medical technicians still exist. It is essential that we maintain enough of these medical professions, because no other health professionals are more valuable to wounded soldiers. It is important to insure that reserve units have a steady supply of qualified health care providers. To in any way cut or stop recruitment efforts would only serve to place medical units back in the situation that they faced after the end of the draft.

The impact of the physician shortage surfaced in 1983 during a mobilization exercise. That exercise revealed serious shortages of medical personnel and equipment, particularly in the reserve components--shortages that would be a war-stopper.[5] This is a major concern for the Army; it surely could hamper combat operations in a full blown mobilization. As we have seen, the Army has taken steps to up-grade their medical mobilization capability. For example, in FY 1987, over 400 Army Reserve medical soldiers gained valuable training experience in support of medical exercises in the U.S. Southern Command (SOUTHCOM). Army Reserve medical soldiers also helped staff the USNS Mercy in conjunction with its initial cruise to the Phillipine Islands from February through July 1987. This medical training with

Army, Navy, and Air Force active and reserve components enhanced Army Reserve tropical medicine training, as well as interservice cooperation. JCS exercises with Army Reserve medical participants include REFORGER and WINTEX, Team Spirit, Bright Star and Yama Sakura.[6]

As a result of a year-long study efforts, the Army has adopted a comprehensive training strategy to improve reserve component training readiness. The goal is to raise RC training readiness by providing more efficient and effective training. The Regional Training Site-Medical (RTS-MED) Program will provide RC medical units an opportunity to train in their wartime mission. The program provides cadre, medical equipment, facilities, and appropriate maneuver and training areas to conduct new equipment training and sustainment on the Deployable Medical System. Two of the seven RTS-MED sites (Camp Shelby, Mississippi, and Fort Indiantown Gap, Pennsylvania) are fully operational, with the remaining sites to be phased in by FY93. The standard site will encompass a five-acre training, classroom, storage, and maintenance area. This will provide the RC medical units with an opportunity to conduct individual and collective unit training in a 400-bed evacuation hospital.[7]

We have thus witnessed a tremendous turn-around in how the military views the Reserve Component medical units. The problems encountered in 1983 focused attention on the USAR Medical Department and the need for medical personnel, equipment, and training. Readiness demands that we recruit sufficient numbers

of highly qualified medical personnel into our reserve units. It demands that we use imaginative, flexible programs to retain them, that we actively counsel them from recruitment to retirement, and that we include them in large-scale, realistic, demanding training exercises. In the 1980's, such a total program evolved...and worked. We need now to maintain this program.

ENDNOTES
CHAPTER VI

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CHAPTER VII

CONCLUSIONS

The Department of the Army expects the Reserve Medical personnel to supply about 60 percent of the Army Medical Department's deployable force in the event we are mobilized. The shortfall in physicans in military service was called a "war stopper" in 1982. However, the numbers have steadily increased from a low of twenty-three percent in 1980 to over seventy-nine percent in 1989.[1]

There has been a tremendous turn-around in physican recruitment in the Reserve Components. The network established by the Surgeon General of the Army in 1979 has done an outstanding job. It systematically contacts physicians along with other health care professionals (except nurses), and explains the programs and benefits. Recruiting doctors in critical specialities has been emphasized.

Personnel Counselors are focused and dedicated officers. Most of the counselors were senior captains or majors. The network sought officers who were mature and able to take on the difficult challenge of recruiting physicians for the Army Medical Department. The experience that they brought with them from their civilian jobs was a major factor in their interactions with physicians. Their knowledge of the medical area gave the AMEDD counselor the necessary expertise to confidently seek out and respond to the doctor. The time that the AMEDD staff took to

personnally interview and evaluate each potential counselor was also a key factor to the success of the counselors. The successful combination of a professional recruiter coupled with a background in the medical field enabled the Army to reduce the physician shortage.

During the early years (1979 to 1984), physicians were recruited from all the various specialities. However, this began to change when counselors started to recruit large numbers of doctors each year who did not process the needed wartime surgical skills, such as pediatricians, psychiatrists and pathologists.[2] Since 1981, the network has recruited over 6000 physicians into the USAR. (See figure 1) The success of the program has been demonstrated and the potential "war stopper" problem has been gradually improving. By 1979, the Army Reserve needed new resolve, new programs, and new inducements to fill the ranks of medical officers...ranks depleted by the exodus of draft-motivated physicians whose legal obligations had been filled and whose younger counterparts had no comparable motivation or obligation to be Army doctors.

With the proposed strength changes, the Army of the 90's is going to be the smallest active Army force since pre-korean war years, with over 50 percent of the military forces allocated to the Reserve Components. In order to ensure that a quality Reserve Medical Corps gets the best physicians possible there must be worthwhile incentives, drill flexibility and a suitable environment in which they can work.[3]

This study began as a description of the historic and difficult decade, 1980-1990, when The Surgeon General of the Army established a system to ensure a needed recruitment of Reserve Component personnel. The study anticipates an annual competition for funds and a potential for a reduction in funding based on a perception that medical shortages were no longer critical problems. But with the realization that any future mobilization cannot afford the luxury of extended periods fortraining or orientation, the initial intent was to offer a sound rationale for the perservation of the USAR network of AMEDD Personnel Counselors.

Constrained defense budgets and the success of the AMEDD Reserve networks may be viewed as threats to the retention of these systems. We are witnessing dramatic changes in Eastern Europe and the potential for drawing down on both Active and Reserve strength. Coupled with budget constrains, these events may affect the AMEDD network. However, this study demonstrates the costly difficulty of obtaining health care providers. Such evidence should persuade any member of the Army Staff from suggesting that we divert funds from the networks to other programs. AMEDD recruiting efforts should not be penalized for their recent successes. To do so would only recessitate more costly restorative efforts a short way down the road.

ENDNOTES
CHAPTER VII

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3. Fact Sheet, The FY 1990-1991 Amended Army Budget, and Analysis. Association of the United States Army, Virginia 1989, pp. 19-20.

RECOMMENDATIONS

1. With the proposed strength changes, the Reserve Components (Army Reserve and National Guard) will provide over half the soldiers for the Total Army. The acquisition and retention of quality people remains the Army's top priority. The AMEDD Procurement Network should be maintained at all cost. It has been successful and has been the major factor in helping to eliminate the physician shortages in the USAR.

2. Physicians incentives should be continued. It is a proven fact that physicians are interested in programs that allow them the opportunity to enhance their skills. If the USAR is to continue to attract quality physicians it is important that we have these viable programs.

3. Flexible programs are essential to physician recruitment. The flexibility the Reserve Components offers to physicians should be extended to allow doctors to take advantage of all opportunities available in the military and civilian medical arena that will increase their skills.

4. Recommend that all Personnel Counselors selected to recruit physicians be senior captains and majors. They should also have some background in the medical field.

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